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# NOTE

## PROMPT PAY STATUTES SHOULD BE INTERPRETED TO GRANT PROVIDERS A PRIVATE RIGHT OF ACTION TO SEEK ENFORCEMENT AGAINST PAYORS

*Monica E. Nussbaum*<sup>†</sup>

### INTRODUCTION

Do health care providers have an explicit or implied right of action to sue third party payors under state prompt pay laws for payment of claims?

The early years of the twenty-first century can be characterized as the period in which health care providers<sup>1</sup> attempted to regain control over claims reimbursement practices. Control over claims payment slowly was lost during the latter half of the twentieth century with the rise of third party payors, and the influence of third party payors in the physician-patient relationship.<sup>2</sup> The most prevalent examples of third party payors are insurance companies and health maintenance organizations.<sup>3</sup> By supporting a dramatic increase in the passage of legisla-

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<sup>1</sup> For the purposes of this paper, "providers" will consist of entities that provide health care services, namely physicians, physician groups, and hospitals.

<sup>2</sup> In a 2003 article, Anish P. Michael states:

[t]he development of health insurance gave rise to managed care in the United States . . . . [M]anaged care transitioned from fee-for-service payment directly from consumers to a capitated system [whereby] . . . health care providers are paid a fixed amount to treat individual patients despite the amount of services given . . . [and where the managed care organization can] review . . . the care demanded by patients and providers.

Anish P. Michael, *Putting Health Care Providers at a Loss and Consumers at Risk: Why HMOs Should Be Held Accountable for the Financial Instability of Their Delegated Networks*, 35 ST. MARY'S L.J. 169, 175 (2003).

<sup>3</sup> A health maintenance organization is "an entity that provides, offers, or arranges for coverage of designated health services needed by plan members for a

tion requiring specific third party health care payors to pay providers on a timely basis, providers began to assert collective power in an attempt to regulate payment policies and practices of third party payors. Prompt pay laws typically require payors to pay clean claims<sup>4</sup> within ten days to two months. Additionally, some prompt pay laws require payors to inform providers of a possible claim deficiency<sup>5</sup> that would result in a delayed payment or no payment within the time specified by statute; otherwise, the claim would be considered valid. .

Currently, two fundamental problems exist with prompt pay statutes.<sup>6</sup> First, do prompt pay statutes grant providers an implied or an explicit right of action? Second, what is a clean claim? Although the focus of this paper is to determine whether a right of action exists or should exist, the definition of a clean claim will be explored. Because prompt pay laws are new, legal issues concerning who can and who should be able to enforce their provisions have yet to be settled. Prompt pay laws were passed to ensure that payors reimburse providers according to a statutory time frame. However, uncertainty exists concerning whether these laws are capable of rectifying the problems for which they were created, such as when payors lose claims, repeatedly request the same information, request information after deadlines, and request unnecessary or unreasonable information.<sup>7</sup>

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fixed, prepaid premium." *Id.* at 176. Individuals who are members of a health maintenance organization or an insurance company are termed the beneficiaries of the health maintenance organization or the insurance company, and these individuals are termed patients regarding their relationship with a health care provider.

<sup>4</sup> See discussion *infra* p. 25.

<sup>5</sup> A deficiency in a claim occurs when data required to process the claim for payment is not provided with the claim, such as a specific billing code or the patient's name. Controversy exists concerning the definition of a deficiency and whether managed care entities are allowed to require specific information which is not usual or customary. Usual or customary information includes identifying patient information such as name, date of birth, social security number, and medical services rendered. Currently, some legislatures are in the process of regulating what information must be provided by providers when submitting claims and regulating how managed care entities must publish their requirements for claim processing.

<sup>6</sup> Robert W. McCann, *State Legislatures Weigh In on Behalf of Providers*, MANAGED HEALTHCARE EXECUTIVE, Sept. 1, 2003, at 17 ("[P]roviders in almost every state have complained that existing laws are ineffectual because of vague standards for clean claims . . . inadequate penalties and cumbersome enforcement procedures.").

<sup>7</sup> See William S. Hammond, *Getting Paid Gets Easier for Michigan's Health Care Providers*, MICH. B.J., Nov. 2002, at 24, 25:

[N]umerous factors have combined in recent years to make it more difficult for health care providers to realize payment from third-party payors on a timely basis. These factors include the administrative burden of complying with various third-party payor claims procedures, the absence of effective

Providers and payors disagree over whether payment policies impact quality of care, cost of health care, and access to health care. Payors contend that payment policies are not problematic because most bills are paid timely and that sufficient legislation governing when and how to pay bills exists.<sup>8</sup> However, providers maintain that although some prompt pay laws exist, they are inadequate in alleviating and rectifying the problems surrounding payment timeframe. Providers argue that without being able to enforce prompt payment of claims, patient care is adversely impacted, as providers financially cannot provide care to patients if the cost of that care is not reimbursed in a timely fashion.<sup>9</sup> Currently, a vast majority of states have enacted prompt pay legislation mandating that managed care organizations pay clean claims within a specified time, typically ranging from fourteen to sixty days, and that managed care organizations inform providers of specific reasons for which a particular claim is either questioned, delayed, or denied.

The purpose of this paper is to determine whether providers should or already do have a private right of action to initiate claims under state prompt pay laws. Although many states have enacted these laws, it is unclear in many cases whether providers have standing to sue payors for violations of these laws or whether the sole enforcement mechanism is the individual states' insurance commissioners. Thus far, two courts have dealt squarely with the issue of whether providers have a private right of action and have reached inconsistent conclusions.<sup>10</sup> In addition, this paper will explore the ability of pro-

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prompt payment laws, the lack of enforcement of such laws when they do exist, and the impracticality of litigating payment disputes on a claim-by-claim basis. These factors, combined with providers' general level of frustration with third-party payor payment practices, has resulted in a number of high profile class action lawsuits against numerous third-party payors alleging prompt pay violations.

(citation omitted).

<sup>8</sup> Wayne J. Guglielmo, *Will the States Cook up a Health Care Fix? Faced with Budget Gaps, a Medicaid Squeeze, and Ballooning Liability Premiums, State Lawmakers Struggle to do More with Less*. MED. ECON., Jul. 12, 2002, at 38, 38:

That ongoing concern strikes some in the managed care industry as excessive. "I know there's some frustration [among providers], but, legislatively, I think this is an area that has been well covered[]" says Susan Laudicina, who tracks state health care policy for the Blue Cross Blue Shield Association's Washington, DC, office.

<sup>9</sup> *HMO Pays More Than \$100,000 Fine for Payment Violation*, HEALTH & MED. WK., Aug. 4, 2003, at 561.

<sup>10</sup> See *Solomon v. United States Healthcare Sys. of Pa.*, 797 A.2d 346 (Pa. Super. Ct. 2002) (holding that providers do not have a right of action to sue as the legislature did not indicate an intent to create a private cause of action); *Grider v. Keystone Health Plan*, No. 2001-CV-05641, 2003 U.S. Dist. LEXIS 16551, at \*25

viders to initiate and sustain causes of breach of contractual obligations, whether the Employee Retirement Income Security Act of 1974 (ERISA)<sup>11</sup> preempts provider claims against third party payors for failing to pay timely, and whether provider advocates – i.e., professional associations – can or should be able to initiate suits on behalf of their constituents. Lastly, this paper will explore the practicality of placing responsibility for enforcement of prompt pay statutes with state insurance commissioners through administrative actions in the context of cost to the health care industry, the incentives to payors to follow prompt pay statutes, and the likelihood that insurance commissioners will enforce these statutes.

## A BRIEF GLIMPSE AT THE IMPACT OF DELINQUENT PAYMENTS

Late payments severely affect the financial stability of health care providers, including individual physician practices, group practices, and hospitals. For example, in California approximately 115 physician groups declared bankruptcy between 1997 and 1999, many due to late payments that prevented the providers from covering their overhead expenses and the direct cost of patient care.<sup>12</sup> The plight of health care providers in California was so severe during this period that the *New England Journal of Medicine* published a review which came to the conclusion that physician groups in California “were engaged in a ‘Darwinian struggle for survival,’ where success depended on ‘avoiding the high-cost patients who need [them] most.’”<sup>13</sup> In California, the impact of provider bankruptcies “caused disruption [in

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(E.D. Penn. Sept. 18, 2003) (holding that providers do have a private right of action because to determine otherwise would be inconsistent with the purpose of the statute).

<sup>11</sup> 29 U.S.C. § 1001 (2000). For more on ERISA, see *infra* text p. 12.

<sup>12</sup> Brant S. Mittler & André Hampton, *The Princess and the Pea: The Assurance of Voluntary Compliance Between the Texas Attorney General and Aetna's Texas HMOs and Its Impact on Financial Risk Shifting by Managed Care*, 83 B.U. L. Rev. 553, 564 (2003). See also Michael, *supra* note 2, at 190-91:

Many of these delegated networks are caught in the middle of a health care plan originated by the HMO and agreed upon by the enrollee. . . . If there is any delay by the HMO to pay set capitation fees, the delegated network is unable to make payment claims. In turn, the delegated entity is liable for violating the prompt pay laws. . . . Providers have trouble continuing to operate when claims are paid untimely. In addition, providers that are at odds with a particular HMO or delegated network are forced to run away enrollees since payment is unlikely. Even with a delegated network filing bankruptcy, the provider will never see the actual amount of the claims filed and must settle for the best possible payout.

(citations omitted).

<sup>13</sup> Mittler, *supra* note 12, at 564.

continuation of medical care] and confusion [about where to seek medical care] for 2.5 million California HMO enrollees.”<sup>14</sup> California was not alone during this period. The Medical Society of New Jersey estimated in 2001 that the impact of unpaid bills due to insurance delays totaled one billion dollars annually to providers within New Jersey.<sup>15</sup>

The billing and collection system of the health care industry is unique to the industry. Third party payors frequently employ a scheme whereby these organizations contract with an intermediary organization that promises to pay the health care costs for the beneficiaries of the health plans offered by the third party payor.<sup>16</sup> Third party payors contract with the intermediary organization in an attempt to limit the specific dollar amount of health care spending for a specific population, regardless of the actual needs of that population.<sup>17</sup> Consequently, the intermediary organization frequently finds that it is expending greater quantities of money in health care costs than the reimbursement total received from the third party payor.<sup>18</sup> Thus, delays and denials in payments to providers increase considerably.<sup>19</sup> This constitutes a financial risk-shifting scheme whereby third party payors shift the financial burden to these intermediary groups.<sup>20</sup> Ultimately, this risk-shifting scheme impacts patient care, quality of care, and the physician-patient relationship.<sup>21</sup> The physician-patient relationship no longer functions solely between the physician and the patient, as intermediary parties become involved in medical decision-making, frequently determining the necessity of health care services, through economic decisions involving utilization review,<sup>22</sup> economic

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<sup>14</sup> *Id.*

<sup>15</sup> Eve Tahmincioglu, *Is Your Health Insurance Hurting Your Credit?*, N.Y. TIMES, May 12, 2002, § 3, at 8 (“Unpaid bills can add up quickly. In New Jersey alone, about \$1 billion in claims go unpaid annually because of insurance delays, according to a survey conducted last year by the Medical Society of New Jersey.”).

<sup>16</sup> See Michael, *supra* note 2, at 181 (“A delegated network is an entity authorized to provide or arrange medical care for HMO enrollees in return for a pre-determined payment.”).

<sup>17</sup> *Id.* at 180.

<sup>18</sup> *Id.*

<sup>19</sup> See *id.*

<sup>20</sup> Mittler, *supra* note 12, at 555 (“MCOs accomplish financial risk shifting either through direct contracts with individual physicians or by contracts with intermediary physician groups.”). See also Michael, *supra* note 2, at 180-81.

<sup>21</sup> See Mittler, *supra* note 12, at 557 (“It is the relationship between the downstream entity and the individual physicians that ultimately affects patient care, the doctor-patient relationship, and the quality of care.”).

<sup>22</sup> Utilization review is a tool used by managed care entities to monitor the treatment practices of providers to ensure that providers are not offering more services than the managed care entity determines necessary.

credentialing,<sup>23</sup> pre-authorization,<sup>24</sup> and post-authorization.<sup>25</sup> In response to the significant impact of the relationship between third party payors and intermediary financial risk bearing parties, specifically in California, New Jersey, and Texas, "the regulatory community throughout the United States has made the regulation of downstream entities its number one priority."<sup>26</sup>

Health care consumers retain some measure of protection, as most states have enacted prompt pay statutes regulating the time frame that an insurance company may legally use to determine whether to make a payment, question a claim, or deny a claim.<sup>27</sup> The time frame typically is between thirty and sixty days; however, health care experts argue that time frames alone are insufficient to correct the problems concerning payment of claims and as a result advocate for more forceful regulation.<sup>28</sup> Consequently, many states have revisited their prompt pay statutes to increase the forcefulness of the statute for violations and to clarify terms and definitions.<sup>29</sup>

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<sup>23</sup> Economic credentialing is defined by the American Medical Association as "the use of economic criteria unrelated to quality of care or professional competence in determining a physician's qualifications for initial or continuing hospital medical staff membership or privileges." AMERICAN MEDICAL ASSOCIATION, Economic Credentialing (AMA Policy H-230.975) available at <http://www.ama-assn.org/ama/pub/category/print/10919.html> (last modified on December 30, 2003).

<sup>24</sup> Pre-authorization is a mechanism whereby managed care entities require providers to request approval to render health care services prior to rendering those services in order to receive reimbursement.

<sup>25</sup> Post-authorization is similar to pre-authorization, except that the authorization for services occurs after the medical care has been rendered.

<sup>26</sup> Mittler, *supra* note 12, at 584-85:

[i]n recent litigation filed against PacifiCare of Texas, Inc., in February 2002, the OAG has returned to the theme of ultimate financial responsibility for the licensed HMO. The lawsuit seeks to hold the HMO financially responsible for the failure of its downstream entities to fulfill the requirements of Texas prompt-pay statutes. In this lawsuit, the OAG asserts that the HMO is 'statutorily prohibited from contractually relieving itself of regulatory responsibility for . . . delegated functions' and may not contractually relieve itself of its responsibility to promptly pay claims in compliance with Texas statutes and regulations.

*Id.* (citations omitted).

<sup>27</sup> Tahmincioglu, *supra* note 15, at 8.

<sup>28</sup> *Id.*

<sup>29</sup> For example,

[d]octors have done better in their fight to get clean claims paid in a timely manner: 46 states now have prompt-pay laws on the books, although they vary widely in their effectiveness. For this reason, lawmakers in Colorado, Hawaii, Kentucky, Maine, Mississippi, and Virginia have gone back and tinkered, adding teeth to weak provisions, clarifying muddled ones, and mandating shorter waits for claims submitted electronically.

Guglielmo, *supra* note 8, at 38. Further "[a] few states are rewriting their laws to

The insurance industry views this legislation as an affront to their field and as a personal attack on its integrity. For example, insurers assert that provider billing errors and lateness in failing claims in conjunction with a lack of uniform paperwork is a primary source of reimbursement problems.<sup>30</sup> According to Karen Ignagni, president of the American Association of Health Plans, a managed-care lobbying group, "[a]ll providers need to move from paper to electronic billing systems if claims are to be paid immediately."<sup>31</sup>

However, providers are battling to remain solvent by initiating suits alleging extortion and fraud in violation of the Racketeer Influenced and Corrupt Organizations Act, (RICO),<sup>32</sup> alleging breaches of contract, violations of fiduciary duty, and violations of federal and state prompt pay statutes in hopes that courts will hold insurers responsible.<sup>33</sup>

In some states, the threat of legal action against managed care organizations has been sufficient to effect positive change within the payment policies and practices of managed care organizations. New Mexico has implemented positive changes in payment practices with prompt pay legislation. According to New Mexico Medical Society Executive Director G. Randy Marshall, "[a] year ago physicians were being paid in excess of 180 days . . . [a]nd now, on average, they are getting paid within 14 to 25 days, so the law has greatly improved things."<sup>34</sup> However, in many states because of lack of enforcement of existing laws and confusion over whether providers do or do not have a right of action pursuant to prompt pay legislation, managed care organizations have been slow to make changes within their payment policies. Consequently, providers should have a right of action to sue

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include tougher provisions. New Jersey, for example, recently revised its law mandating that electronic claims that are "clean," or clearly covered by insurance, be paid within 30 days and clean paper claims within 40 days; under its old law, clean claims had to be paid within 60 days." Tahmincioglu, *supra* note 15, at 8.

<sup>30</sup> Tahmincioglu, *supra* note 15, at 8.

<sup>31</sup> *Id.*

<sup>32</sup> 18 U.S.C. §§ 1961-1968 (2000).

<sup>33</sup> For instance,

[a] massive lawsuit aims to change all that. The action was brought by a consortium of high-powered attorneys last year on behalf of the nation's 600,000 doctors. In the suit—which is being heard in the federal district court in Miami—the California, Texas, and Georgia medical associations, the Denton County Medical Society (Texas), and 20 individual doctors accuse many of the nation's largest for-profit HMOs of using extortion and fraud to systematically steal from them in violation of the Racketeer Influenced and Corrupt Organizations Act (RICO).

Neil Chesnow, *Will Managed Care Die in Court?*, MED. ECON., Sept. 3, 2001, at 30.

<sup>34</sup> Wayne J. Guglielmo, *Prompt-pay Laws Are Finally Getting Teeth*, MED. ECON., Jan. 22, 2001, at 47, 52.



managed care organizations for late or no payment in violation of their respective state prompt pay statute.

### DOES ERISA PREEMPT PROVIDERS FROM BRINGING STATE LAW CLAIMS?

Managed care organizations and other defendants to suits alleging breach of contract claims, violations of RICO, and violations of state prompt pay statutes are likely to move for dismissal of the case arguing that the claims are preempted by ERISA. ERISA was enacted to protect employees from mismanagement and abuse of employer sponsored pension plans.<sup>35</sup> ERISA has evolved through continued legislative efforts to include regulation of welfare benefit plans including medical and hospital benefits.<sup>36</sup> Sections 502 and 514 of ERISA preempt state laws that challenge denial of benefits under an ERISA plan and "relate to" ERISA plans in an attempt to control the plan design.<sup>37</sup> If an employer directly manages a welfare benefit plan, or hires a managed care organization to manage the welfare benefit plan, the plan most likely will be classified as an ERISA plan and is not subject to state regulation.<sup>38</sup> Therefore, pursuant to §§ 502 and 514, these entities will argue that the suits alleging violation of state law are preempted by federal law.

However, not every issue involving managed care organizations falls under ERISA preemption. In *In re Managed Care Litigation*, a Florida district court determined that "ERISA applies to any employee benefit plan, provided that it is established or maintained by an employer or employee organization engaged in commerce or in any industry or activity affecting commerce."<sup>39</sup> In determining whether a particular claim is preempted, courts must address the preliminary question of whether the provider's claim against the managed care organization is a direct cause of action or whether it is consequent to a patient's cause of action.<sup>40</sup> If the claim is independent of a patient's cause of action, then the claim is not preempted by ERISA; however,

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<sup>35</sup> U.S. DEPT. OF LABOR, EMPLOYEE BENEFITS SECURITY ADMIN., HISTORY OF EBSA AND ERISA, available at <http://www.dol.gov/ebsa/aboutebsa/history/html> (last visited on February 29, 2004).

<sup>36</sup> *Id.*

<sup>37</sup> Michael J. Jackson, Jr., *Considerations in Medicare Reform: The Impact of Medicare Preemption on State Laws*, 13 ANNALS HEALTH L. 179, 197 (2004).

<sup>38</sup> "States generally cannot directly regulate private employer-sponsored health plans, mandate that employers even offer or pay for health insurance, tax private employer-sponsored health plans, or indirectly affect employer-sponsored health plans by imposing substantial costs on plans." *Id.* at 198.

<sup>39</sup> 135 F. Supp. 2d 1253, 1267 (S.D. Fla., 2001).

<sup>40</sup> *Id.* at 1267-68.

if it is consequential to a patient's cause of action, then ERISA applies.<sup>41</sup> Two types of contracts extend from ERISA plans. The first contract is between the plan and a patient which informs the patient as to what care the patient is entitled to receive under the plan. The second contract is between the plan and the provider and sets forth what medical care the provider is responsible for providing to the patients of the ERISA plan and the reimbursement rates for that care. Providers cannot bring causes of action alleging that ERISA plans violated the contract between the plan and the patient by denying care to the patient. Providers can only bring claims alleging that the plan failed to abide by the contract between the plan and the provider, essentially alleging that the plan failed to reimburse the provider for medical care provided.

In *In re Managed Care Litigation*, the court ruled that the plaintiff's claims alleging bundling<sup>42</sup> and downcoding<sup>43</sup> by the defendants were not preempted by ERISA as the state law contract claims did not "relate to" the ERISA plans and could be analyzed as a breach of contract claim without the need to interpret or refer to ERISA.<sup>44</sup> In the context of prompt pay claims, the plaintiffs alleged that managed care organizations were violating state prompt pay laws by failing to submit payment for provided medical care within the statutory time frame. The plaintiffs did not allege a cause of action derivative to a patient's cause of action. In other words, the plaintiffs did not allege that the managed care entity violated the contractual provisions between the managed care organization and its beneficiaries by denial of care that was specifically provided for in the contract. The plaintiffs alleged that the managed care organization failed to reimburse providers for services rendered to patients pursuant to the contractual relationship (either explicit or implied) between the managed care organization and the provider, not pursuant to the contract between the patient and the managed care organization. In other words, a provider will agree to provide medical care for the managed care organization's enrollees in consideration for timely and appropriate reimbursement from the managed care organization. Prompt pay claims do not allege that managed care organizations fail to follow their individual contracts with their beneficiaries. The Ninth Circuit has found that causes

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<sup>41</sup> D. Brian Hufford, *Managed Care Litigation: The Role of Providers*, in HEALTH CARE LITIGATION: WHAT YOU NEED TO KNOW AFTER PEGRAM, at 487, 499 (PLI Corp. L. Practice Course, Handbook Series No. B-1216, 2000).

<sup>42</sup> Bundling occurs when a payor combines several claims and remits one payment for those claims.

<sup>43</sup> Downcoding occurs when a payor changes the coding of a claim such that the value of the claim decreases.

<sup>44</sup> 135 F. Supp. 2d at 1268.

of action that cannot be sustained by beneficiaries because the actions ensue from the agreement between the provider and the managed care organization for payment, and not from ERISA plan benefits, are not preempted by ERISA.<sup>45</sup> Therefore, so long as providers' claims are asserting enforcement of contracts, ERISA preemption should not be at issue.<sup>46</sup>

Lawsuits against managed care organizations which happen to be classified as ERISA plans alleging violation of state law claims "such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan – are relatively commonplace."<sup>47</sup> In *Mackey v. Lanier Collection Agency & Service, Inc.*, both the petitioners and the United States as amicus curiae admitted that ERISA § 514(a) did not preempt suits alleging violations of common place state law claims even though these claims impacted ERISA plans and their beneficiaries.<sup>48</sup> If providers sue payors because they are not being reimbursed according to their contracts, then the providers are suing as creditors and not on behalf of their patients.<sup>49</sup>

In *Baylor University Medical Center (BUMC) v. Arkansas Blue Cross Blue Shield (ABCBS)*, BUMC sued ABCBS for breach of contract and for late payments of claims pursuant to Texas Insurance Code Annotated art. 3.70-3C, §3A.<sup>50</sup> BUMC and ABCBS had entered into a contract whereby BUMC would provide medical services to ABCBS beneficiaries.<sup>51</sup> BUMC provided medical services to an ABCBS beneficiary and submitted a clean claim to ABCBS that was partially reimbursed after the statutory time requirements of the Texas Prompt Pay Statute.<sup>52</sup> ABCBS removed the suit to federal court alleging ERISA preemption; however, the district court ruled that removal was improper as ERISA did not preempt BUMC's claims.<sup>53</sup> The court stated that preemption of state law claims occurs when "(1) the state law claim addresses areas of exclusive federal concern, and (2) the claim directly affects the relationship between traditional ERISA entities – the employer, the plan and its fiduciaries, and the participants and beneficiaries."<sup>54</sup> In this case, the court found that enforcing

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<sup>45</sup> See Hufford, *supra* note 41, at 498.

<sup>46</sup> See *id.*

<sup>47</sup> *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 833 (1988).

<sup>48</sup> *Id.*

<sup>49</sup> Hufford, *supra* note 41, at 498.

<sup>50</sup> 331 F. Supp. 2d 502, 504, 511 (N.D. Tex. 2004).

<sup>51</sup> *Id.* at 504-05.

<sup>52</sup> *Id.* at 505.

<sup>53</sup> *Id.* at 505, 512.

<sup>54</sup> *Id.* at 507.

contracts was not an area of exclusive federal concern and that requiring payment within a state's statutory time frame did not impede the relationship between an ERISA plan and its beneficiaries.<sup>55</sup>

If providers were barred from suing for enforcement of their contracts with ERISA benefit plans, this "preemption of provider contract claims would 'defeat rather than promote' ERISA's goal to 'protect the interests of employees and beneficiaries covered by benefit plans.'"<sup>56</sup> Providers cannot afford to contract with organizations that would be exempt from contract enforcement, as providers then would be providing health care without any assurance of appropriate and timely reimbursement. The aforementioned consequence defeats ERISA's goal as the availability of, and access to health care would be severely restricted by reduction in the numbers of providers willing to provide health care to beneficiaries of ERISA benefit plans. Without guarantee of timely and appropriate reimbursement, providers would be unlikely to voluntarily treat beneficiaries of ERISA plans. Moreover, health care providers do not lie within the scope of ERISA<sup>57</sup> and do not participate in the bargain<sup>58</sup> in which limitations on the right to sue are accepted in exchange for ERISA's protections. The decision in *In re Managed Care Litigation* held that ERISA preemption does not bar providers from bringing contract claims.<sup>59</sup>

## HEALTH CARE PROVIDERS SHOULD HAVE A RIGHT OF ACTION PURSUANT TO PROMPT PAY STATUTES

Providers should have a private right of action to initiate suit against a payor for failure to pay claims within the time frame established by a state's legislature, even if the state's prompt pay statute does not explicitly grant such a right. As discussed in the next sec-

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<sup>55</sup> *Id.* at 509, 511-12.

<sup>56</sup> *In re Managed Care Litigation*, 135 F. Supp. 2d 1253, 1268 (S.D. Fla. 2001).

<sup>57</sup> *Id.* at 1268.

<sup>58</sup> Hufford, *supra* note 41, at 499.

<sup>59</sup> *In re Managed Care Litigation*, 135 F. Supp. 2d at 1268. *See also* Hufford, *supra* note 41, at 497:

[t]o combat the breach of contract claims by providers, managed care defendants may argue that the claims are preempted under ERISA, in that they "relate to" ERISA plans, such that the compensatory damages sought by the providers would be precluded. *Mertens v. Hewitt Associates*, 508 U.S. 248, 255 (1993) (ERISA only permits "appropriate equitable relief," not compensatory damages, which is "the classic form of legal relief"). While such a defense has repeatedly been asserted in actions brought by individual providers, however, it appears to be unsuccessful, so long as the provider is pursuing his own contractual rights and not stepping in the shoes of his patient.

tion, providers can sue payors under contractual principles; however, whether providers can sustain a cause of action against payors under newly created state prompt pay legislation is not yet settled. To date, only two courts have directly addressed this issue.<sup>60</sup>

### The *Solomon v. Aetna* Case

In *Solomon v. United States Healthcare System of Pennsylvania*, Dr. Mark Solomon and Aetna, Inc. (Aetna) entered into an agreement whereby Solomon would provide specified health care services to the beneficiaries of Aetna's health care policies.<sup>61</sup> In return, Aetna would reimburse Solomon for the services rendered according to the pre-specified rate structure.<sup>62</sup> In order for Solomon to see and treat a subscriber, the subscriber first would have to receive pre-certification from his primary care physician.<sup>63</sup> Solomon initiated a suit against Aetna claiming that Aetna failed to make payments for services rendered according to their contractual arrangements.<sup>64</sup> Solomon alleged "breach of contract, breach of an implied covenant of good faith and fair dealing, unjust enrichment, fraud, conversion, and negligent misrepresentation."<sup>65</sup> However, the trial court dismissed all the counts except breach of contract.<sup>66</sup> Thereafter, Solomon amended the complaint to include a claim alleging violation of Pennsylvania's Prompt Pay statute, the Pennsylvania Quality Health Care Accountability and Protection Act (Health Care Act).<sup>67</sup> The Pennsylvania Superior Court in *Solomon* determined that providers do not have a right of action because the Pennsylvania Legislature did not indicate an intent to create a private right of action in the drafting of the legislation nor would allowing the suit be consistent with the purpose of the legislation even though providers constitute the class for which the statute was created.

The *Solomon* Court used the three element test established by the United States Supreme Court in *Cort v. Ash* to determine whether or not a plaintiff has standing to initiate a suit.<sup>68</sup> First, the plaintiff must

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<sup>60</sup> *Solomon v. United States Healthcare Sys. of Pa.*, 797 A.2d 346 (Pa. Super. Ct. 2002); *Grider v. Keystone Health Plan*, No. 2001-CV-05641, 2003 U.S. Dist. LEXIS 16551 (E.D. Penn. Sept. 18, 2003).

<sup>61</sup> *Solomon*, 797 A.2d at 348.

<sup>62</sup> *Id.*

<sup>63</sup> *Id.*

<sup>64</sup> *Id.*

<sup>65</sup> *Id.*

<sup>66</sup> *Id.*

<sup>67</sup> *Solomon*, 797 A.2d at 348.; PA. STAT. ANN. tit. 40, §§ 991.2101-.2166 (West 1999).

<sup>68</sup> *Solomon*, 797 A.2d at 352, citing *Cort v. Ash*, 422 U.S. 66, 78 (1975).

be a member of a class for which the legislation was created.<sup>69</sup> Second, the legislation must indicate an intention to create or deny a remedy to this particular class.<sup>70</sup> Third, allowing a plaintiff to bring suit must be consistent with the purpose of the legislation.<sup>71</sup> The *Solomon* court, found that the first element of the *Cort* test was met, but that the second and third factors were not satisfied.<sup>72</sup> In *Solomon*, the court stated,

[o]ur review of the Act reveals no indication of legislative intent, explicit or implicit, to create a private remedy. . . . Moreover, the regulations promulgated under the Health Care Act evidence a strong indication that no private cause of action exists. Instead, the regulations provide an administrative procedure for a health care provider to file a complaint with the Insurance Department.<sup>73</sup>

However, whether the administrative remedy provided by the Health Care Act is effective in ensuring that managed care entities pay providers according to the requirements outlined in the Act is questionable, especially in light of the fact that to date no managed care entities have been fined in Pennsylvania.<sup>74</sup> The *Solomon* court stated that they were unaware of any intent to create a private remedy for providers to initiate causes of action pursuant to the Health Care Act.<sup>75</sup> What is the purpose of codifying a rule without a right of action, implied or explicit, that enables the aggrieved party to seek reimbursement? In and of itself, the legislation indicates an intent by the General Assembly to force managed care entities to reimburse providers within forty-five days.<sup>76</sup>

The *Solomon* court erred in requiring specific oral or written evidence of legislative intent to create a private right of action; the second element of the *Cort* test should have been found to exist. Additionally, the *Solomon* court incorrectly applied the third element of the *Cort* test. The third element analyzes whether creating a private right of action which would allow a provider to bring a cause of action would be consistent with the purpose of the legislation. The legisla-

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<sup>69</sup> *Id.*

<sup>70</sup> *Id.*

<sup>71</sup> *Id.*

<sup>72</sup> *Id.* at 352-53.

<sup>73</sup> *Id.*

<sup>74</sup> See Appendix *infra* p. 233.

<sup>75</sup> PA. STAT. ANN. tit. 40 § 991.2166 (West 1999) (the legislature requires that all clean claims are to be paid within forty-five days of receipt).

<sup>76</sup> *Id.*

tion exists to force managed care entities to timely reimburse providers for services rendered. Allowing providers to sue managed care entities which fail to meet the statutory requirements would reflect the spirit of the legislation.

### *The Grider v. Keystone Health Plan Case*

The decision by the *Solomon* court barring a private right of action was criticized by the federal district court in *Grider v. Keystone Health Plan*.<sup>77</sup> The district court held that providers have a private right of action pursuant to the Health Care Act.<sup>78</sup> In the *Grider* case, Dr. Grider and her affiliates provided approximately 4,000 patients with medical services.<sup>79</sup> These patients were primarily insured by defendant Keystone Health Plan Central (Keystone), organized under the Pennsylvania Health Maintenance Organization Act.<sup>80</sup> Grider and Keystone entered into an HMO-physician agreement whereby Grider would provide medical services to Keystone enrollees in return for payment.<sup>81</sup> Grider alleged numerous federal claims and two state claims: violation of the prompt payment provision of the Health Care Act and breach of an implied contractual duty of good faith and fair dealing.<sup>82</sup>

The *Grider* court determined that the first and third elements of the *Cort* test for standing were met: i.e., that the plaintiffs were members of a special class for which the legislation was created and that implying a private cause of action was consistent with the underlying purpose of the statute.<sup>83</sup> In contrast to the *Solomon* Court, the *Grider* court applied the Pennsylvania Statutory Construction Act of 1972<sup>84</sup> to determine how to analyze the second prong of the *Cort* test.<sup>85</sup> Pursuant to § 1921(c) of the Statutory Construction Act, the intent of the General Assembly may be ascertained when a statute is not explicit by reviewing "the mischief to be remedied, the object to be obtained and the consequences of a particular interpretation."<sup>86</sup> The *Grider* court states that even though the legislative history does not indicate an intent to provide a private right of action, "a private cause of action

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<sup>77</sup> *Grider v. Keystone Health Plan*, No. 2001-CV-05641, 2003 U.S. Dist. LEXIS 16551, at \*86 (E.D. Penn. Sept. 18, 2003).

<sup>78</sup> *Id.* at \*102.

<sup>79</sup> *Id.* at \*4.

<sup>80</sup> *Id.*

<sup>81</sup> *Id.* at \*5.

<sup>82</sup> *Id.* at \*8.

<sup>83</sup> *Grider*, 2003 U.S. Dist. LEXIS 16551 at \*83-86.

<sup>84</sup> 1 PA. CONS. STAT. ANN. § 1921 (West 1995).

<sup>85</sup> *Grider*, 2003 U.S. Dist. LEXIS 16551 at \*86-95.

<sup>86</sup> *Id.* at \*92.

should be implied because failure to do so would be absurd and would neither further the object of the statute nor remedy the mischief.”<sup>87</sup> Without a private right of action under the Pennsylvania statute, providers have no remedy to enforce the statute against alleged violators. The statute does not authorize the insurance commissioner to force the payors to make timely payments, to force payors to pay delinquent payments, or to force payors to pay interest on delinquent payments.<sup>88</sup> The statute solely authorizes the insurance commissioner to impose a nominal fine to be paid to the Department of Insurance for violations of the statute, this penalty does not aid providers.<sup>89</sup> Consequently, what would be the point of the prompt pay statute and why would the Pennsylvania General Assembly have passed the statute if the statute was in effect not enforceable?

To date, the vast majority of state insurance commissions have been wholly ineffective in enforcing state prompt pay statutes. When the Michigan Legislature passed a prompt pay bill in late 2000, Governor John Engler vetoed the bill.<sup>90</sup> He explained to the Michigan Senate that he supported requiring timely payment of healthcare claims, but that he did not support the legislation because he did not want the insurance commissioner to act as a bill collector or an arbiter over disputed claims between physicians and payors.<sup>91</sup> Placing the enforcement of prompt pay laws within the responsibility of a state insurance commissioner is likely to reduce the effectiveness of the legislation. Insurance commissioners are unlikely to fine and force third party payors to pay providers for the claim plus interest until a sufficiently large number of providers or a significantly large sum of money is at issue. Michigan Insurance Commissioner Frank Fitzgerald compared the Michigan legislation with New York’s prompt pay law, which has been backlogged with administrative cases.<sup>92</sup> Consequently, Commissioner Fitzgerald estimated that to enforce the legislation and expected caseload in Michigan, he would need to increase the size of his department by approximately one-fifth of its current size.<sup>93</sup> After these statements were made in Michigan, prompt pay legislation was passed that enabled the Commissioner of the Office of Financial and Insurance Services to fine a violator up to \$1000 per

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<sup>87</sup> *Id.* at \*94.

<sup>88</sup> *Id.* at \*90.

<sup>89</sup> *Id.* at \*92.

<sup>90</sup> Neil Versel, *Prompt Pay Delay: Advocates Renew Push after Michigan Governor Vetoes Bills*, MOD. PHYSICIAN, Jan. 29, 2001.

<sup>91</sup> *Id.*

<sup>92</sup> *Id.*

<sup>93</sup> *Id.*



violation or \$10,000 for multiple violations.<sup>94</sup> However, the legislation does not bar a complainant from bringing a lawsuit nor is filing an administrative complaint a necessary pre-condition to filing a lawsuit.<sup>95</sup>

In Illinois, the Department of Insurance has yet to issue a fine against a payor, because the Department believes that only three percent of all complaints filed concerning health insurance were due to late payments.<sup>96</sup> Additionally, providers have been somewhat hesitant about involving insurance commissioners. Providers fear that requests for enforcement actions might be detrimental to their practices and lead to retaliation from third party payors.<sup>97</sup> Granting providers a right of action whereby they can sue managed care companies on their own behalf reduces the administrative burden on the insurance commissioners; reduces the expense of enforcing these state laws, as fewer parties would be involved; de-politicizes enforcement mechanisms; and most importantly, grants the affected parties status to pursue a statutorily created remedy.

### **DOES CONTRACT LAW AFFORD PROVIDERS AN ALTERNATE METHOD TO OBTAIN A REMEDY?**

Regardless of whether providers can initiate suits under state prompt pay statutes, providers can bring claims under breach of contract. Third party payors contract with providers to specify which medical services will be covered and for what monetary amount those services will be reimbursed.<sup>98</sup> Thus, the argument third party payors are required to reimburse providers according to the terms of the contract and within a reasonable time makes sense. To maintain a suit against a third party payor for failure to follow prompt pay statutes, particularly in a state where a provider does not have a right of action pursuant to the prompt pay statute, the provider must argue specific

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<sup>94</sup> Hammond, *supra* note 7, at 27.

<sup>95</sup> *Id.*

<sup>96</sup> Robert Kazel, *Insurers Say Prompt Pay Not a Big Issue; Doctors Disagree*, AMER. MED. NEWS, Sept. 15, 2003, at 17 available at <http://www.ama-assn.org/amednews/2003/09/15/bisb0915.htm>.

<sup>97</sup> See Deborah A. Grandinetti, *Scoop Up Every Dollar You've Earned*, MED. ECON., Sept. 3, 2001, at 117 ("One more last-ditch resource: the state insurance commissioner. Savvy billers don't use this until all other remedies have failed, because they know it can put the practice on the plan's blacklist. Practices that go this route must be confident that they can document that an insurer has repeatedly delayed payment without reason, and that they've done everything possible to resolve the problem.").

<sup>98</sup> See generally *Baylor Univ. Med. Ctr. v. Ark. Blue Cross Blue Shield*, 2004 U.S. Dist. LEXIS 278 (N.D. Tex. 2004).

breaches of contract instead of “underlying policies that would be applicable to all managed care companies.”<sup>99</sup> The provider cannot simply allege that the third party payor generally fails to reimburse providers. Providers must allege that the third party payor failed to abide by the requirements specified in the contract. For example, if a contract between a provider and a third party payor specifies that the third party payor will reimburse the provider for services rendered at X number of dollars within Y number of days, and the third party payor does not reimburse accordingly, then the provider can allege breach of contract by the third party payor.

Yet, some courts are unwilling to grant providers relief according to contract principles. For example, in *Solomon v. US Healthcare Systems of Pennsylvania and Aetna*, the court, in discussing contract interpretation, determined that holding the defendant responsible for reimbursement within thirty days, when the time frame for reimbursement was not specified in the contract, was not a prerequisite to preventing injustice.<sup>100</sup> The court stated,

We observe the well-settled rule that when interpreting a contract, a court must construe it as it is written, giving effect to the clear language and plain meaning of the words. . . . [T]he law is clear that a court ‘may imply a missing term in a parties’ contract only when it is necessary to prevent injustice and it is abundantly clear that the parties intended to be bound by such term.’ Appellants have not established that an injustice would be prevented by inserting a ‘reasonable time’ term into the parties’ agreement, nor are we persuaded that there is any clear intent by the parties to be bound by such a term. Moreover, we do not perceive that imposition of a thirty day time period for payment of claims as suggested by Appellants

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<sup>99</sup> “In such cases, however, the key issue appears to be that the lawsuit is attacking underlying policies that would be applicable to all managed care companies, rather than targeting specific conduct that reflects a breach of duty by a particular defendant.” Hufford, *supra* note 41, at 496.

<sup>100</sup> *Solomon v. United States Healthcare Sys. of Pa.*, 797 A.2d 346, 348 (Pa. Super. Ct. 2002):

Appellant Dr. Solomon has an agreement with Appellee Aetna, Inc. to provide certain health care services to Aetna’s subscribers, for which Aetna makes payment. . . . Appellants commenced this action alleging that Aetna failed to make payment for medical services rendered according to their agreement, specifically by improperly denying some claims and unreasonably delaying payment on others.

is 'essential to a determination of [the parties'] rights and duties.'<sup>101</sup>

The *Solomon* court indicated that forcing parties that have entered into a contractual relationship to make payments within a time frame that is not bargained for in the contract would not prevent injustice. In *Solomon*, the contract failed to specify a time frame for reimbursement for medical services provided to the beneficiaries of the defendant. However, Pennsylvania enacted a prompt pay statute that requires managed care entities to reimburse providers for clean claims within forty-five days of receipt.<sup>102</sup> If a managed care entity fails to submit payment, then ten percent per annum shall be added to the amount of the claim.<sup>103</sup> Although the court found that inserting a "reasonable time" clause into the contract would not prevent an injustice, the court fails to clarify what a "reasonable time" would be. Presumably, the time frame of forty-five days created by the Pennsylvania legislature would be reasonable.

In *Grider*, the court criticized the *Solomon* decision, which denied the existence of a private right of action pursuant to state prompt pay statutes.<sup>104</sup> However, the *Grider* court dismissed the plaintiff's counts alleging violation of duty of good faith and fair dealing, stating that the plaintiffs' claims essentially mirrored their RICO claims.<sup>105</sup> Thus, the *Grider* court reasoned that if the claim alleging violation of a duty of good faith and fair dealing can be brought under another cause of action, the courts will be unlikely to recognize a cause of action for the violation of a duty of good faith and fair dealing. This reasoning does not indicate that the courts have determined that the violation does not exist. Instead, the courts are less likely to recognize this cause of action indicating a preference for causes of action based on statutory violations, and a preference that the same alleged violations are brought under one cause of action instead of multiple causes of action. According one commentator,

[r]elying, at least in part, on a breach of contract theory should also provide plaintiffs with a means to avoid the ad-

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<sup>101</sup> *Id.* at 349-50. Additionally, "[t]he trial court noted that during the parties' fifteen year relationship, no specific time period for payment ever developed, nor was interest ever paid on claims. Certainly the parties' long-standing course of performance was relevant to a determination of whether the parties intended to impose such an obligation." *Id.* at 350.

<sup>102</sup> PA. STAT. ANN. tit. 40 § 991.2166 (West 1999).

<sup>103</sup> *Id.*

<sup>104</sup> *Grider v. Keystone Health Plan*, No. 2001-CV-05641, 2003 U.S. Dist. LEXIS 16551, at \*94, 97-98 (E.D. Penn. Sept. 18, 2003).

<sup>105</sup> *Id.*

verse implications of *Pegram* and *Maio v. Aetna, Inc.*, 2000 U.S. App. LEXIS 19172 (3d Cir. Aug. 11, 2000), each of which dismissed cases brought against managed care companies for violation of ERISA and [RICO], respectively.<sup>106</sup>

In light of the *Grider* case, plaintiffs should ensure that their complaints allege specific violations of contractual provisions in addition to alleging violations of a duty of good faith and fair dealing, especially if the violation of a duty of good faith and fair dealing can be brought under another cause of action. In *Batas v. Prudential Insurance*, a New York case, the court held that the plaintiffs “base[d] their contractual claim on allegations that the procedures utilized by defendants were not those promised in their contractual agreements, [and] [s]uch a claim would not be precluded by the subsequent legislation”<sup>107</sup> and thereby “rejected Prudential’s contention that the plaintiffs’ claims were preempted by state regulations.”<sup>108</sup> Case law indicates that if plaintiffs can support allegations of specific contract violations, these causes of action are likely to withstand motions to dismiss based on preemption defenses of state legislation and ERISA.<sup>109</sup>

If providers can maintain causes of action based on breach of contract theory, why should providers be granted a private right of action pursuant to prompt pay statutes? Enabling providers to have a right of action to enforce prompt pay statutes not only reinforces the purpose of the statute, but it also allows for greater continuity regarding the reimbursement policies and procedures of managed care entities.

### WHAT IS A CLEAN CLAIM AND HOW DOES IT IMPACT TIMELY REIMBURSEMENT?

The fundamental element common to the vast majority of prompt pay statutes is the requirement of filing clean claims. Clean claims

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<sup>106</sup> Hufford, *supra* note 41, at 496 (citation omitted). For another perspective, see Chesanow, *supra* note 32, at 31:

“Doctors aren’t the only ones crying foul.” Richard A. Epstein, a professor at the University of Chicago Law School, deplors “the effort to try to elevate every ordinary breach-of-contract claim into a criminal or quasi-criminal offense. That makes it impossible for people to deal with these issues in a responsive fashion. The idea that this would count as racketeering seems to say in the crudest terms that the guys who are running HMOs are the blood brothers of Tony Soprano.”

<sup>107</sup> *Batas v. Prudential Ins. Co. of Am.*, No. 107881/97 (N.Y. Sup. Ct., Mar. 28, 1999), available at [http://www.nycourts.gov/comdiv/Law\\_20Report\\_20Files/July\\_201999/batas.htm](http://www.nycourts.gov/comdiv/Law_20Report_20Files/July_201999/batas.htm).

<sup>108</sup> Hufford, *supra* note 41, at 496.

<sup>109</sup> *Id.*

must be paid within a specific time frame; however, states were not clear in defining what constitutes a clean claim when these statutes were first passed. Recently, states and courts have started defining what constitutes a clean claim. In Pennsylvania, a clean claim is defined as:

[a] claim for payment for a health care service which has no defect or impropriety. A defect or impropriety shall include lack of substantiating documentation or a particular circumstance requiring special treatment which prevents timely payment from being made on the claim. The term shall not include a claim from a health care provider who is under investigation for fraud or abuse regarding that claim.<sup>110</sup>

In general, a clean claim is a claim that includes customary information about the patient and the care provided. Both the federal government and the insurance industry require a claim to provide standard identifying information such as patient name and date and location of service for the claim to be considered a clean claim.<sup>111</sup> However, ambiguity still exists in the definition of a clean claim. In the Pennsylvania statutory definition, the terms "substantiating documentation" and "particular circumstance" are not defined. Consequently, the terms are subject to differing interpretations based on whether one is a provider or a payor. Additionally, ambiguity in what constitutes a clean claim lies in that both commercial insurers' regulations and Medicaid prompt pay rules "provide that a claim is not clean unless it contains such additional documentation as is required by the . . . Health Plan. Thus, a Health Plan has some discretion with respect to the information it may require for a claim to be clean."<sup>112</sup> The provisions that allow health plans to determine what is necessary and relevant for a claim to be processed create considerable frustration for providers as health plans due to the lack of consistency among health plans as to what constitutes a clean claim. As a result, states are revising their prompt pay statutes to better define what constitutes a clean claim or to require payors to publish and provide notice to providers of what elements are necessary for a claim to be considered clean.

Payors blame the clean claim problem on the lack of technology implemented into the billing practices of providers.<sup>113</sup> Payors argue

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<sup>110</sup> PA. STAT. ANN. tit. 40 § 991.2102 (West 1999).

<sup>111</sup> Hammond, *supra* note 7, at 26 (citation omitted).

<sup>112</sup> *Id.*

<sup>113</sup> See Mary Chris Jaklevic, *Prompting Promptness; Fines Mount Against Seven Insurance Firms For Dragging Feet With Payments*, MOD. HEALTHCARE, Aug. 20, 2001, at 12, 13 ("In a written statement, the insurers' group blamed 'lack of in-

that if providers would invest in filing claims electronically, problems with payment timeframes would disappear.<sup>114</sup> Although electronic filing of claims might aid in reducing filing errors, the definition of what constitutes a clean claim remains unanswered. More importantly, the problem lies in that the definition of a clean claim varies from one managed care entity to the next. Consequently, providers are constantly working to ensure that the differing and individual requirements of managed care entities are appropriately satisfied.

## SHOULD PROVIDER ADVOCATES HAVE A RIGHT OF ACTION ON BEHALF OF THEIR CONSTITUENTS?

Provider advocates<sup>115</sup> should be able to initiate suits on behalf of their members. Provider advocates have significant power to effect change, even if courts determine that they should not have standing to initiate and maintain suits for violation of prompt pay statutes. For example, the Texas Medical Association (TMA) leads the nation in ensuring that its constituents are represented and that the Texas Prompt Pay statute is enforced. The TMA first compelled Texas Insurance Commissioner Jose Montemayor to realize the consequences of late payments by inviting him to visit with county medical societies and by lobbying him to enforce the prompt pay statutes already in existence.<sup>116</sup> In response, Montemayor stated, "I have to say in all fairness that the TMA had not misrepresented the situation. . . ."<sup>117</sup> Furthermore, Montemayor created four mechanisms by which to enforce prompt payment.<sup>118</sup> First, an official was appointed to manage slow-pay complaints. Second, an online complaint form was created. Third, prompt-pay workshops were scheduled around the state.

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vestment in technological resources by physicians and other providers' for payment disputes. Lucksinger said, 'A great many of the claims problems we are experiencing would disappear overnight if physicians would file their claims electronically.'").

<sup>114</sup> See Kazel, *supra* note 100, at 17 ("The insurance industry argues that the increasing number of doctors who've started filing claims electronically over the past few years has speeded turnaround of claims and made the laws less relevant. And, they say, their numbers show most claims are processed within legal time limits.").. See also Jaklevic, *supra* note 117, at 13.

<sup>115</sup> Provider advocates are organizations to which health care providers are members. These organizations can be general physician organizations, hospital associations, or specialty groups. Examples include the American Medical Association, the Ohio Hospital Association, the Texas Medical Association, and the American Society of Anesthesiology.

<sup>116</sup> Wayne J. Guglielmo, *America's Best Medical Society?*, MED. ECON., Aug. 6, 2001, at 77, 78.

<sup>117</sup> *Id.*

<sup>118</sup> *Id.*

Fourth, Montemayor promised that the Texas Insurance Department would create rules to improve compliance.<sup>119</sup>

In *Hunt v. Washington State Apple Advertising Commission*, the United States Supreme Court held that

an association has standing to bring suit on behalf of its members when: (a) its members would otherwise have standing to sue in their own right; (b) the interests it seeks to protect are germane to the organization's purpose; and (c) neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit.<sup>120</sup>

Whether a provider advocate will have standing to bring suit is dependent upon the jurisdiction. However, this paper argues that all providers should have standing to bring suit pursuant to a state's prompt pay laws. Consequently, the first element of the *Hunt* test would be satisfied, if the providers have standing.

The second element of the *Hunt* test is satisfied since provider advocates exist to lobby both locally and nationally for their constituents along the many facets of a provider's practice. Provider advocates exist not only to further science, ensure quality of care, and to establish and enforce standards of care, but to also lobby the interests of their constituents. Also, prompt payment of claims is of primary importance to providers. If any questions exist as to whether the second prong of the *Hunt* test is satisfied, the answer should be clearly found when reviewing the charter and mission statement of the organization in question. With that determination, granting standing to a provider advocate would reduce the administrative burden on the courts and on states' Departments of Insurance, as provider advocates would be better able to consolidate caseloads and organize lawsuits against specific managed care organizations suspected of violating prompt pay laws.<sup>121</sup> Additionally, allowing provider advocates to litigate these suits would increase the likelihood that cases are brought that otherwise might not be, due to either the fear of retribution by the managed

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<sup>119</sup> *Id.*

<sup>120</sup> *Hunt v. Wash. State Apple Adver. Comm'n*, 432 U.S. 333, 343 (1977). See also Hufford, *supra* note 41, at 506.

<sup>121</sup> See Chesanow, *supra* note 32, at 35:

[t]he groups, which have a combined membership of nearly 90,000, hope to underscore physicians' problems with managed care. 'The HMOs say that our evidence is anecdotal and isolated and only represents 15 or 50 clients,' says Lamb. 'But with the Georgia, Texas, and California medical groups joining the suit, there are 87,000 doctors saying, 'They're doing the same thing to me.'

care organization or because of insufficient financial resources to initiate and sustain an action against a managed care organization.

The third prong of the *Hunt* test creates difficulty in terms of how much force an action by a provider advocate would have. The third prong states that the participation of an individual member should not be required with respect to the claim asserted or the relief requested.<sup>122</sup> Arguably, if monetary damages are included in the requested relief, then it is likely that provider advocates would not be able to bring claims independent of their constituents. However, prompt pay laws typically delineate the relief available – payment of the claim plus interest for the lateness.<sup>123</sup> Because the relief that can be requested is limited to statutory requirements, provider advocates should be able to satisfy the third element of the *Hunt* test and maintain the claims independently of their constituents. Provider advocates would not file causes of action requesting damages; the sole restitution requested would be that outlined in the prompt pay statute. However, for a provider advocate to bring the claim, constituents would have to file some type of report with the provider advocate declaring the violation and providing the advocate with sufficient proof that the violation occurred.

If courts determine that provider advocates have standing to bring claims but not without the direct involvement of constituents if monetary damages are desired, then provider advocates should focus their claims on injunctive or declaratory relief.<sup>124</sup> In this event, provider advocates need to establish that the suit is intended to bring about relief that would compel payors “to alter their pattern and practice of conduct, not that they seek monetary recoveries for their members” in order for their suits to survive motions to dismiss.<sup>125</sup> In this event, providers either would have to join the provider advocate’s suit or initiate a suit independent of that of the advocate in order to request payment plus interest. However, in the long term, suits brought by provider advocates are more likely to effectively and positively change the claims payment policies of managed care entities and to force state insurance departments to enforce prompt pay legislation due to the power held by provider advocates.

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<sup>122</sup> *Hunt*, 432 U.S. at 343.

<sup>123</sup> See PA. STAT. ANN. tit. 40 § 991.2166 (West 1999).

<sup>124</sup> Hufford, *supra* note 21, at 506 (discussing forms of relief available to an association of health care providers when members are not able to participate in the suit).

<sup>125</sup> *Id.* at 507.



## CONSEQUENCES OF PLACING ENFORCEMENT OF PROMPT PAY STATUTES WITH THE STATE INSURANCE COMMISSIONER

Lastly, this paper explores the practicality of the current system of placing responsibility for enforcement of prompt pay statutes with state insurance commissioners through administrative actions in the context of cost to the health care industry, incentive to payors to follow prompt pay statutes, and likelihood that insurance commissioners will enforce these statutes. The effectiveness of this system is largely determined by the willingness and the ability of a state insurance commissioner to enforce prompt pay statutes. Few state insurance commissioners have been proactive in enforcing prompt pay legislation by fining payors for violations and by forcing payment.<sup>126</sup> To create a system whereby prompt pay legislation is continually enforced, regardless of the desire or ability of an insurance commissioner and regardless of changes of personnel within state insurance departments, prompt pay legislation should be interpreted to include a private right of action for providers to enforce timely reimbursement.

Healthcare in America constitutes approximately fourteen percent of the gross domestic product.<sup>127</sup> Frequent discussions take place across the United States about the cost of a physician visit, the cost of a hospital stay, and the cost of healthcare in general. When healthcare providers are not reimbursed timely and appropriately, the cost of financing their receivables increases and affects their ability to provide care. As previously mentioned, many providers have had to close their doors because of insufficient funds due to untimely and inadequate payment by third party payors, causing much disruption in care, confusion about care, lower quality of care, and inadequate access to care.<sup>128</sup> Prompt pay statutes were created to help address these problems. If providers were paid on a timely basis and with appropriate reimbursement, then many of these negative consequences would be lessened if not significantly reduced. However, placing enforcement of these statutes with an entity that may not enforce the law in a particular case and barring those who desire enforcement from initiating and maintaining causes of action pursuant to the statutes effectively nullifies the validity and purpose of the statutes. Additionally, by increasing the number of parties required to enforce the statute,

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<sup>126</sup> See Appendix at 42.

<sup>127</sup> AGENCY FOR HEALTHCARE RESEARCH & QUALITY, HEALTH CARE COSTS, AHRQ PUB. No. 02-P033, Sept. 2002, available at <http://www.ahrq.gov/news/costsfact.htm>.

<sup>128</sup> See Mittler, *supra* note 12, at 564.

(i.e., by adding an insurance commissioner into the mix) the cost of enforcement increases; consequently, increasing the cost of care.<sup>129</sup>

Placing the responsibility for enforcement of prompt pay statutes with state insurance commissioners creates the likelihood that prompt pay enforcement will become politicized and based upon total quantities of dollars not paid pursuant to the statute, instead of whether or not a violation occurred. Consequently, payors may not have sufficient incentives to change their payment practices to avoid these fines. Moreover, if the sole enforcement mechanism of state prompt pay statutes resides with state insurance commissioners, providers are essentially without reparation for the damages caused by late payments. However, providers are not without power to compel insurance commissioners to review the problems caused by late or no payments. For example, the Texas Medical Association essentially forced Insurance Commissioner Montemayer to look into and address the failure of managed care organizations to make timely and appropriate payments. Consequently, Texas has led the nation in imposing significant fines totaling more than thirty-six million dollars against managed care entities for violations.<sup>130</sup>

Granting a private right of action to providers will result in an increased caseload for an already overburdened judicial system; however, with clear legislative guidelines disposition of cases should be relatively straightforward. Prompt pay statutes revolve around the clean claim doctrine. Since the term "clean claim" remains highly ambiguous, courts will not be able to rubberstamp a case and say that a payor has violated or not violated the statute. Until the issue of what exactly constitutes a clean claim is resolved and clearly defined by legislatures, courts will remain disinclined to litigants who bring these types of cases.

The most promising solution is for provider advocates to assert their collective power and force state legislatures to clearly define what constitutes a clean claim and to explicitly create a private right of action for providers and provider advocates. With the ambiguity of what constitutes a clean claim removed, courts would easily be able to review whether a managed care entity violated a prompt pay statute by failing to reimburse providers within the statutorily created time frame. Creating clear rules would eliminate economic imbalances that

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<sup>129</sup> See Jaklevic, *supra* note 117, at 13:

"The true cost of these penalties and restitution, in terms of a higher cost of healthcare, is ultimately going to be paid by businesses and consumers in the state of Texas," said Tom Lucksinger, president of the Texas Association of Health Plans. Lucksinger is president and chief executive officer of Houston-based Am Care Health Plans.

<sup>130</sup> Appendix *infra* p. 233.

enable a managed care entity to keep a suit in litigation until a provider runs out of resources. Furthermore, provider advocates are more likely to track which managed care entities more egregiously violate prompt pay statutes. Removing sole enforcement responsibility from a state insurance commissioner and placing responsibility with the affected parties creates a system whereby enforcement is more likely to be sought.

## CONCLUSION

Plaintiffs face the challenge of persuading courts that prompt pay issues are appropriate for courts because of the expertise courts hold in assessing "contractual and statutory duties and obligations."<sup>131</sup> Michigan's prompt pay statutes are a positive sign for health care providers; however, the insurance commissioner will play a large role in the effectiveness of the statute.<sup>132</sup> Of the states that have passed prompt pay statutes, only fourteen have Departments of Insurance which have enforced the prompt pay statute and imposed fines, required payment plus interest, or both.<sup>133</sup> The monies paid in these states total over fifty-one million dollars.<sup>134</sup> It is difficult to imagine that with fourteen states imposing fines and restitution worth this amount of money, that prompt payment is not an issue for the remaining states. Additionally, it is easy to see that providers are filing bankruptcy because of late payments. If providers have a right of action to maintain a suit attempting to enforce prompt payment for claims, the quantity of dollars spent in fines and restitution will increase initially, but will drop off after payors begin to follow prompt pay statutes by paying a claim, denying a claim, or questioning a claim within the statutorily allotted time frame. Regardless of how the courts decide to rule on provider right of action over the next several years, providers can sustain suits alleging contractual violations

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<sup>131</sup> Hufford, *supra* note 41, at 497.

<sup>132</sup> See Hammond, *supra* note 7, at 27:

[w]hile Michigan's prompt pay statutes definitely represent a step in the right direction for health care providers, the effectiveness of these statutes will depend, in large part, upon the manner in which complaints are handled by the Commissioner of the Office of Insurance and Financial Services. Swift and decisive action by the commissioner, including the imposition of substantial penalties, as have been seen in other states, will ensure that the law has enough 'teeth' to be effective. If on the other hand, these statutes do nothing more than convert the time providers wait for third-party payors to pay claims into time spent waiting for the commissioner to enforce the rules, these statutes may largely be viewed as ineffective.

<sup>133</sup> See Appendix *infra* p. 231.

<sup>134</sup> *Id.* at 234.

without fear of ERISA preemption. Yet, suits alleging breach of contract will not be as effective in changing the reimbursement policies and practices of managed care entities as suits alleging violation of state prompt pay statutes.

State legislatures should create a statutory right of action for providers pursuant to prompt pay statutes. Additionally, provider advocates should be able to initiate and sustain causes of action on behalf of their constituents pursuant to this right of action. Provider advocates should use the considerable power they hold to compel state insurance commissioners to recognize the claims payment problems that, as stated in the paper, have detrimental consequences on the quality of care and availability of care provided to beneficiaries of managed care organizations. Until state legislatures create an explicit statutory right of action, courts should determine that effective enforcement of prompt pay statutes will only occur if the courts find an implied right of action allowing providers to enforce timely reimbursement for services pursuant to state prompt pay statutes.

## APPENDIX

### *State Prompt Pay Statutes Comparisons And Penalties Imposed*

STATE	PAYMENT TIMEFRAMES	PENALTY	PENALTIES/ RESTITUTION/ INTEREST
AL	HMOs: 45 working days Health insurance pending: 30 working days for elec- tronic; 35 for paper	1.5% per month	\$224,600
AK	Paper: 20 working days; Electronic: 10 working days	<\$250: 5% payment or \$5, whichever is less; > \$250: 2% of payment	
AZ	All claims types: 30 days after claim approved	Legal interest rate	
AR	Paper: 45 calendar days Electronic: 30 calendar days	12% annually	
CA	Non-HMOs: 30 working days HMOs: 45 working days	15% annually; \$10 add'l non-inclusion of interest with payment	\$3,801,500
CO	All claim types: 45 working days	10% annually; >90 days 3% claim amount	\$141,750
CT	All claim types: 45 working days	15% annually	

STATE	PAYMENT TIMEFRAMES	PENALTY	PENALTIES/ RESTITUTION/ INTEREST
DE	All claim types: 30 working days	Maximum allowable lending rate	
DC	All claim types: 30 working days	1.5%: 31-60 days 2%: 61-120 days 2.5% thereafter	
FL	HMO claims: 35 days Non-HMO claims: 45 days Claim requesting additional information: 120 days	10% annually	\$984,000
GA	All claim types: 15 working days	18% annually	\$1,705,779
HI	Paper: 30 days Electronic: 15 days	15% annually; fines may also be assessed	
ID	All claim types: 30 working days, effective 7/31/2003	Legal rate of interest	
IL	All claim types: 30 days All insurers must change contract for compliance with state law	9% annually	
IN	All claim types: 45 days	6% annually 2001-02; 4% annually 2003	
IA	Same as time for group health plans established by the USDOL pursuant to 29 CFR pt. 2560 in effect on 1/1/2002.	10% annually	
KS	All claim types: 30 days	1% annually	
KY	All claim types: 30 days to pay or deny	12% annually if 31-60 days; 18% annually if 61-90 days; 21% over 90 days	
LA	Paper: submitted within 45 days + 45 days to pay Electronic: 25 days	1% of unpaid balance; add'l 1% penalty added for each 25 days remains unpaid	
ME	All claim types: 30 days	1.5% per month	\$3,365,000
MD	All claim types: 30 days	1.5% per month 31-60 days; 2% per month 61-120 days; 2.5% per month over 121 days	\$2,675,000
MA	All claim types: 45 days after receipt	1.5% per month	
MI	Non-contracted providers: 60 days	12% annually	
MN	All claim types: 30 days	1.5% per month	
MS	Paper: 35 days Electronic: 25 days	1.5% per month	
MO	All claim types: 30 days for payment or denial	1% per month	\$100,160

STATE	PAYMENT TIMEFRAMES	PENALTY	PENALTIES/ RESTITUTION/ INTEREST
MT	All claim types: 30 days	18% annually	
NE	All claim types: within 15 days of receipt acknowledgment	None listed	
NV	All claim types: 30 days	Refer to state code 99.040 or provider contract	
NH	Paper: 45 days Electronic: 15 days	1.5% monthly	
NJ	Paper: 40 days Electronic: 30 days	10% annually	
NM	Paper: 45 days Electronic: 30 days	1.5% monthly	
NY	Current, all claim types: 45 days Pending: paper, 30 days; electronic, 15 days (proposed 3/2002)	Current: 12% annually Pending: 2% of claim amount	\$8,263,000
NC	All claim types: 30 days for payment or denial	18% annually	\$545,000
ND	All claim types: 15 days	None given	
OH	All claim types: 30 days	12% annually	
OK	All claim types: 45 days	10% annually >6 interest rate same as US rate	
OR	All claim types: 30 days	12% annually	
PA	All claim types: 45 days	10% annually	
RI	All claims: 30 days	12% annually	
SC	Paper: 45 days Electronic: 30 days (effective 7/1/2003)	6% annually	
SD	Paper: 45 days Electronic: 30 days	None indicated	
TN	Paper: 30 days Electronic: 21 days	1% monthly	
TX	HMOs only: 45 days	18% annually	\$29,350,020*
UT	All claim types: 30 days for payment or denial	May be applied according to formula	
VT	All claim types: 45 days	12% annually	
VA	All claim types: 45 days	Daily legal rate of interest	
WA	90% monthly volume: 30 days; 90% monthly volume: payment or denial in 60 days	1% monthly	\$305,000
WV	Paper: 40 days Electronic: 30 days	10% annually	
WI	All claim types: 30 days	12% annually	
WY	All claim types: 45 days	10% annually	

<b>Total Fines, Penalties, and Restitution (approximately)</b>	<b>\$51,534,059</b>
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# Estimates are that outstanding claims remain in the millions.

\* Data not complete, reports indicate that over \$36 million in restitution has been paid to providers.

+ This chart, current January 2004, was compiled from charts published by various authors. See DON SELF & ASSOCIATES, INC., PROMPT PAY LAWS BY STATE, *available at* <http://www.donself.com/documents/prompt-pay.doc> (last visited January 3, 2004); AMERICAN MEDICAL ASSOCIATION, PROMPT PAYMENT FINES, *available at* [http://www.ama-assn.org/ama1/pub/upload/mm/368/fines\\_chart\\_8\\_04.pdf](http://www.ama-assn.org/ama1/pub/upload/mm/368/fines_chart_8_04.pdf) (last visited January 11, 2004); KAREN ZUPKO & ASSOCIATES, INC., PROMPT PAY STATUTES AND REGULATIONS, *available at* <http://www.karenzupko.com/Resources/tools/Downloads/prompt%20pay%202003.doc> (last visited December 29, 2003).